

Application for Renewal Certificate of Registration

Fiscal Year End Date: _____

Date Submitted: _____

COMAR 32.02.01.13 fully states requirements for information to be submitted when applying for a Renewal Certificate of Registration.

1.	Name of Community:	
	Chief Executive Officer:	
	Street Address (mailing):	
	City/State/Zip Code:	
	Telephone Number:	Email Address:

2.	Executive Director or Manager:	
	Street Address (mailing):	
	City/State/Zip Code:	
	Telephone Number:	Email Address:

3.	Chief Financial Officer:	
	Street Address (mailing):	
	City/State/Zip Code:	
	Telephone Number:	Email Address:

4.	Name of any affiliate, parent or subsidiary person (see Human Services Article § 10-401(g) and (q); COMAR 32.02.01.01B(27)):	
	Street Address (mailing):	
	City/State/Zip Code:	
	Telephone Number:	

5.	BREAKDOWN OF LIVING UNITS		
	<i>Please indicate occupancy as of the end of the fiscal year.</i>		
	Independent Living Units	Registered _____	Occupied _____
	Assisted Living Beds	Registered _____	Occupied _____
	Comprehensive Care Beds	Registered _____	Occupied _____
	Total Number of Units/Beds	Registered _____	Occupied _____
	Assisted Living Units	_____	Occupied _____
<p>A check in the amount of \$ _____ covering _____ registered units, as of the filing date, is attached. The renewal fee is \$25.00 per unit and includes all independent living units, assisted living beds, and comprehensive care beds that are <u>registered with the Maryland Department of Aging</u>. List any changes in unit configurations proposed from the PRECEEDING year with an explanation. Please also specify changes in unit configurations proposed for the succeeding year.</p>			

6.	A copy of each of the following must be enclosed with this renewal application:		
	<p>1) The <i>most recent license(s) issued by the Maryland Department of Health (“MDH”) for comprehensive care and assisted living beds</i>. Please include an explanation if the number of assisted living beds and comprehensive care beds stated in Block Number 5 above is not the same as the number of beds which appear on the license from MDH.</p>		
	<p>Enclosed _____</p>		
<p>2) The most recent Certificate of Need Exemption letter or Certificate of Need issued by the Maryland Health Resources Planning Commission or the Maryland Health Care Commission.</p>			
<p>Enclosed _____</p>			

7.	<p>Section E of COMAR 32.02.01.13 states that every 3 years a provider shall submit an actuarial study. Requirement exceptions are listed in Section D of the regulation.</p>	
	<p>Date of Last Actuarial Study Submission: _____</p>	
	<p>Emailed as PDF: _____</p>	

Attach Exhibits A through F ONLY if there have been changes in the information since the last application was filed or the required information has not been filed previously with the Department.

Change	No Change	EXHIBITS
_____	_____	Exhibit A
_____	_____	<ul style="list-style-type: none"> Information on the organizational structure and management of the Provider, including any relevant names, addresses, and telephone numbers not specified below, as described in Human Services Article § 10-411(c). Please refer to the specific subsection of the law named above.
_____	_____	<ul style="list-style-type: none"> The names, address, and telephone numbers of stockholders holding at least a 10 percent interest in the stock corporation, if the Provider is a stock corporation.
_____	_____	<ul style="list-style-type: none"> The names, addresses, and telephone numbers of the members of the non-stock corporation, if the Provider is a non-stock corporation.

Exhibit B

- The names, addresses, occupations, and telephone numbers of the members of the governing body, if the Provider is a corporation.
- The name, address, and telephone number of the chief executive officer of the Provider, or any other affiliated parent or subsidiary organization if different from the information provided in Item No. 1 on Page 1 of this application.

Exhibit C

- The information required in Human Services Article § 10-411(c)(2)(vii) for anyone having a 10 percent or greater financial equity or beneficial interest in the Provider and who is anticipated to provide goods, premises, or services to the facility or Provider of a value of \$10,000 or more within any fiscal year. Please refer to the statute specified.

Exhibit D

- A copy if any current document as it pertains to the legal organization of the Provider, including corporate charter, articles of association, by-laws, trust agreement, membership agreement, partnership agreement, or similar instrument or agreement pertaining to the legal organization of the Provider as stated in Human Services Article § 10-411(c)(3).

Exhibit E

- A statement of any current or prior affiliation with a religious, charitable, or other nonprofit organization; the extent of any affiliation, and the extent, if any, to which the affiliate organization will be responsible for the financial and contractual obligations of the Provider.

Exhibit F

- A brief narrative description of the physical facility.

THE FOLLOWING EXHIBITS MUST BE FILED ANNUALLY WITH THE RENEWAL APPLICATION:

Exhibit G

As indicated in the spaces provided below, the following financial information has been checked for completeness prior to submission. The undersigned attests that the information submitted herein is true and accurate.

Signature

Title (for Chief Financial Officer)

- (1) **Certified Financial Statement:** An **ORIGINAL audited financial statement** for the preceding fiscal year, prepared in accordance with generally accepted accounting principals, which include the principles expressed in the American Institute of Certificated Public Accountants’ “Audit and Accounting Guide for Health Care Organizations”.

“Certified Financial Statement” means a complete audit prepared and certified by an independent certified public account. Human Services Article § 10-401(c).

Enclosed _____ **Emailed as PDF:** _____

- (2) **An Operating Budget** for the **CURRENT** operating fiscal year (the year you are operating in when filing this application) and a **projected operating budget** for the next **SUCCEEDING** fiscal year. Budgets must be prepared in accordance with generally accepted accounting principles and **should be presented in a manner that is consistent with the income statement shown in the Provider’s Certified Financial Statement.** Cash operating budgets are not appropriate. Submit in Excel format.

Current Year Enclosed (Excel) _____ **Succeeding Fiscal Year Enclosed** (Excel) _____

- (3) **A Cash Flow Projection** for the **CURRENT** fiscal year and the **NEXT TWO (2)** fiscal years that has been prepared in accordance with generally accepted accounting principles. **The cash flow projections must be presented in a manner that is consistent with the cash flow statement presented in the Provider’s Certified Financial Statement.** Submit in Excel format.

Current Fiscal Year Enclosed (Excel) _____ **Next Two Fiscal Year Enclosed** (Excel) _____

- (4) **Operating Reserves** – (1) A letter to the Department from the Certified Public Accountant showing a) the calculation used to determine the Operating Reserves; b) the amount actually set aside, **and c) satisfaction of the 25% operating reserve requirement, effective 1/1/2023, in accordance with Human Service Article § 10-420(b)(1)(ii);** or (2) A disclosure of that same information in the Provider’s Certified Financial Statement. See Human Services Article § 10-420(b)(1)(i)–(ii); Human Services Article § 10-420(c); Human Services Article § 10-421(a)–(b).

Enclosed _____

- (5) **CCAC-CARF Ratios for 2023**– Please submit the following ratios **and the basis for the ratio calculation** by contract type. Submit in Excel format.

- Net Operating Ratio
- Net Operating Margin Ratio – Adjusted
- Operating Ratio
- Operating Margin Ratio
- Total Excess Margin Ratio
- Days Cash on Hand
- Debt Service Coverage Ratio
- Age of Facility (Information Only)

***If any ratios are below the median, please briefly explain why this will or will not impact the CCRC’s provision of Continuing Care and financial stability in the coming years. An application filed without sufficient written explanations for ratios below the median will not be considered complete.**

Enclosed Items G1, 2 (Excel), 3 (Excel), 4, and 5 (Excel): _____

Exhibit H A statement of the current or proposed utilization of any public-funded benefit or insurance program in the financing of care.
Enclosed _____

Exhibit I The most recent table of fee structure, including escalator or other automatic adjustment provisions.
Enclosed _____

Exhibit J The form and substance of any advertising campaign or proposed advertisement and other promotional materials not previously filed with the Department.
Enclosed _____

Does the community have a web page on the Internet? **Yes** _____ **No** _____
If yes, please file the form and substance of the community's web pages not previously filed with the Department.
Enclosed _____ **Web page address:** _____

Exhibit K The Disclosure Statement required by Human Services Article §§ 10-424 and 10-425 and COMAR 32.02.01.21. Please identify any changes from the previously submitted Disclosure State by **redlining or blacklining any additions, deletions, or changes. Include any revisions necessary to reflect the change to the operating reserve requirements effective 1/1/2023 in accordance with Human Services Article § 10-420(b)(1)(ii).**
Enclosed _____

Emailed _____

Exhibit L A statement that provides the date(s) of the meeting(s) held the previous year with the Provider's subscribers in accordance with Human Services Article § 10-426.
Enclosed _____ **Date of the Meeting:** _____

Exhibit M An update of any renovation or expansion activities proposed during the preceding year or proposed for the current fiscal year.

Exhibit N A projection of the number of subscribers who will require nursing home care and an estimate of the life expectancy of future subscribers.

Other Exhibits Additional pertinent information may be labeled as Addendum 1, 2... and included with this application behind the exhibits listed above. **However, proposed changes to the form of any continuing care agreement may not be submitted as part of this renewal application; instead, such changes must be submitted separately to the Department.**

Human Services Article § 10-408 states that no provider shall enter into or renew a contract for continuing care in this state without the appropriate certificate of registration.

Human Services Article § 10-413(b)(1) provides that if the application with accompanying information is not received by the Department within the 120-day period, the Provider will be charged the additional per-unit late fee provided in COMAR 32.02.01.13F.

The undersigned attests that the information submitted herein is true and accurate.

Notary Seal/Stamp **(required)**:

(Print Name)

(Signature)

(Executive Director or Manager Title)

Send renewal package electronically to:

ccrchousingservices.mdoa@maryland.gov